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Toward a Phenomenological Psychotherapy for Schizophrenia

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Abstract
During the last decades, research in phenomenological psychopathology has provided a vast array of insights that are invaluable for understanding the experiential worlds of patients with schizophrenia. Precisely, knowledge of patients' experiences is a necessary basis for a sound and thoughtful psychotherapy. This is especially important in psychotherapy for schizophrenia, where patients' experiences may not always be easily accessible or understandable. In the available literature, we found only scattered suggestions for a translation of insights from phenomenological psychopathology into psychotherapeutic practice. The aim of this article is to offer a preliminary translation. First, we outline characteristics of the experiential worlds in schizophrenia, highlighting what we call "core experiences" and "experience-near concepts." Then we explore the psychotherapeutic methods and strategies that can be developed and elaborated on the basis of the accumulated research in phenomenological psychopathology, drawing also on experiences from a phenomenologically informed psychotherapy unit at the University Psychiatric Hospital of Ljubljana. Here, we propose principles of a phenomenological psychotherapy for schizophrenia, dividing them into the following subgroups: (1) overall goals, (2) general attitudes, (3) main domains, and (4) therapeutic strategies. The unique value of phenomenological psychotherapy seems to lie in its ability to capture the heart of the patients' experiences and their inherent vulnerabilities and then use these insights to inform psychotherapeutic interventions.

Introduction

Ronald Bassman [1], author of *A fight to be*, who at the age of 23 years was diagnosed with schizophrenia and who later earned a doctorate and worked as a licensed psychologist, states: "I remain frustrated that mental health professionals have been slow to accept the value of experience-based knowledge and have not integrated that wisdom into the services they provide" [2]. Drawing on research in phenomenological psychopathology of schizophrenia, the aims of this article are to provide an

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overview of experience-based knowledge and to outline possible ways of integrating these insights in psychotherapeutic approaches for patients with schizophrenia.

Phenomenological psychopathology has a long tradition of a thorough and systematic approach to the study of anomalous and psychotic experiences in schizophrenia. With the notion of "phenomenology," we refer to phenomenologically oriented research that draws on the continental philosophical tradition of phenomenology that includes prominent philosophers such as Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, etc. In other words, we are not using "phenomenology" in its ordinary meaning in Anglophone psychiatry, where it simply designates "description of mental phenomena" [3]. Today, phenomenological psychopathology or "phenomenological-anthropological psychiatry," as it is also sometimes named, denotes, as Wiggins and Schwartz [4] put it, "an ongoing research program rather than an achieved theory or set of categories."

During the last decades, research in phenomenological psychopathology has been blooming, resulting in a vast and systematic array of insights which, in our view, are invaluable for understanding the experiential worlds of patients with schizophrenia. This clinical research direction enables us to partially understand what it might be like to experience oneself, others, and the world as patients with schizophrenia often do. It offers resources for grasping the complexity of experiential alterations and the deep vulnerability that accompanies being in a world that may appear deprived of the ontological securities and natural certitudes (e.g., of space, time, and causality) that otherwise ground our existence.

Precisely, knowledge of patients' experiences is, in our view, a necessary basis for any sound and thoughtful psychotherapy. This is perhaps especially important for psychotherapy of schizophrenia, where patients' experiences may not always be easily accessible or understandable. Of course, patients may still appreciate a psychotherapy that is based on a trustful alliance and imbued with empathic concerns for their wellbeing. However, such psychotherapy may also be experienced as somewhat shallow if it is not grounded in a genuine understanding of their condition. In other words, the psychotherapist must know what he or she is treating, i.e., he or she must possess and convey an understanding of the altered experiential life in schizophrenia. With appropriate interviews (vide infra), we can now explore patients' experiences in detail and acquire insights into their individual experiential configurations and inherent vulnerabilities, and these insights can inform decisions on how to plan, structure, and carry out suitable psychotherapeutic interventions.

Despite a long tradition of research in phenomenological psychopathology, the many findings have rarely been incorporated into concrete psychotherapeutic approaches. Nonetheless, many classical authors in phenomenological psychopathology emphasize a potential for psychotherapy, and some of them also present ideas on how to apply their insights in actual psychotherapy [5]. In contemporary phenomenological research, we also find scattered suggestions for such a translation of phenomenological insights into psychotherapeutic practice (vide infra).

In the following sections, we outline characteristics of the experiential worlds in schizophrenia, highlighting what we call "core experiences" and "experience-near concepts." Subsequently, we explore the psychotherapeutic methods and strategies that can be developed and elaborated on the basis of the accumulated research in phenomenological psychopathology of schizophrenia. These methods and strategies are informed also by insights from other existing psychotherapies for schizophrenia and by experiences from a psychotherapy unit at the University Psychiatric Hospital of Ljubljana, where a program for psychotherapy of schizophrenia has been based on a phenomenological approach since 2005.

Experiential Worlds in Schizophrenia

It is not easy to describe or grasp what is it like to suffer from schizophrenia, i.e., what a patient experiences and goes through [6]. Some might even claim that attempts to understand schizophrenia are futile since schizophrenia is basically incomprehensible, or that such an understanding can never be generalized because everyone experiences it in his or her own unique way. It is certainly true that the experiential life of patients with schizophrenia is not always straightforwardly graspable for others and that the symptomatology of schizophrenia, as in other mental disorders, is permeated by biographical details and colored by the patients' cultural-historical embedment. However, phenomenological exploration of the experiential life of patients with schizophrenia reveals that such variance in clinical presentation appears on the backdrop of a typical, psychopathological Gestalt, characterized by a trait-like constellation of "fundamental symptoms" (signs) such as autism, ambivalence, formal thought disorders, and disorders of affect [7], and "anomalous self-experiences" (also called "self-disorders") such

as feelings of being radically different from others, a diminished sense of self, common sense problems, transitivism, quasi-solipsistic experiences, and polymorphous anxiety (vide infra). In schizophrenia, psychosis may be related to stressors or it may be more continuous, but crucially it often emerges from such initial experiential alterations. For example, an experience that it is as if certain thoughts in one's stream of consciousness are not generated by oneself (*Gedankenenteignung*) may acquire a delusional elaboration, where the patient comes to believe that these alien thoughts are, in fact, generated by someone else (thought insertion as a first rank symptom).

In the last 2 decades, systematic, phenomenologically informed empirical studies have documented that anomalous self-experiences hyperaggregate in schizophrenia spectrum disorders but not in other mental disorders [8], that they show a high degree of temporal stability [9, 10], and that they predict incident cases of schizophrenia spectrum disorders [11, 12]. In our view, anomalous self-experiences are not only a promising phenotype for pathogenetic and etiological research but, as common denominators of experiential life in schizophrenia spectrum disorders, they also hold a unique but so far unrealized potential for informing and guiding an experience-based, phenomenological approach to psychotherapy for schizophrenia.

Here, we present a collection of "core experiences" in schizophrenia spectrum disorders. We also emphasize, in italics, important "experience-near concepts," articulating particular mental phenomena that have been described mostly in phenomenological psychopathology but also in general clinical psychopathology and psychodynamic investigations or even been coined by patients themselves. In the final part of this section, we briefly present the fundamental disturbances in schizophrenia, as they are hypothesized in phenomenological psychopathology. These disturbances are also called the *generative disorders* (French: *troubles générateurs*), since they are supposed to "lie" at the core of a mental disorder, generating, shaping, and prefiguring the range of symptoms and signs that may emerge and keeping them to some extent connected.

Core Experiences and Experience-Near Concepts

Patients with schizophrenia often report that they have felt fundamentally different from others (German: *Anderssein*) long before their first acute psychotic episode. Some patients report that this feeling has been present from early childhood and their first memories, while others describe that it emerged in early adolescence [13]. *Anderssein* refers to enduring and pervasive feelings of being *ontologically different* from others or simply "wrong" as some patients put it. For some patients, this feeling may verge on something ineffable. However, others describe it as a feeling of not being a natural or real human being or of being categorically different from others – e.g., one patient said, "I've always felt as if others could almost smell that I was different. They could simply feel that I was a different animal in the herd. I always felt like a giraffe among rhinos" [14]. Often, these feelings of difference are intertwined with feelings of being *estranged* from the shared-social world (French: *aliénation mentale*), i.e. patients do regularly not feel at home or at ease in the world and among others. This is reminiscent of Heidegger's concept of *uncanniness* (German: *Unheimlichkeit*), by which he sought to articulate an experience of profound unfamiliarity, which he also describes as the feeling of "not being at home" (*unheimlich* literally means "non-homely") [15]. For many patients, these feelings of being different resonate with inferiority feelings, which are sources of uneasiness and solitude but also sometimes of shame, despair, and suicidality [16].

In relation to the feelings of being different, patients also very often report *problems with common sense*, which, at their core, reflect an inability to simply take for granted what others consider obvious or matter of fact (German: *Verlust der natürlichen Selbstverständlichkeit*) [17]. In the social domain, patients typically report that they feel uneasiness and uncertainty in relating to others. For example, they describe that they find it difficult to grasp the unwritten rules of social interaction and that they therefore cannot tell what is relevant or irrelevant or appropriate or inappropriate to say or do in various social situations. Some patients report that they, before striking up a conversation with someone, prepare themselves minutely by imagining and playing out all possible scenarios that a certain conversation with another may take. Such a tendency to analyze social situations, including others' behaviors and reactions, are expressions of a *hyperreflective stance*. Hyperreflection may also take elements in the environment or aspects of oneself as the object of reflection. The latter sometimes leads to forms of *self-monitoring*, which may be operative alongside the patients' interactions with others, making spontaneous and smooth engagements difficult. The patients may feel anxious, helpless, and *perplexed* in the sense of being aware of their inability to master the situation (German: *Ratlosigkeit*) [18].

Along similar lines, patients may experience a profound sense of vulnerability and *defenselessness* (German:

Wehrlosigkeit) [19]. An important manifestation of this kind of vulnerability is an experience of frozenness or paralysis in social situations. Some patients may, after experiencing it a few times, fear it and some report that they avoid certain social situations due to it. Notably, we are not implying that experiences of frozenness or paralysis are the cause of social withdrawal and isolation, which are negative symptoms for which little is known regarding their etiology. We merely draw attention to the fact that some patients apparently link their own tendency to socially withdraw to their experiences of frozenness or paralysis in certain social situations. Crucially, some patients prefer a generally withdrawn (but not negatively experienced) position that is balanced or compensated by certain ways of relating to the social world, whereas other patients find strategies to generally be with others and only withdraw when it becomes too stressful and paralyzing and afterwards quickly find their way back to others. This intricate equilibrium, which is variously negotiated in individual patients, has been found to support stabilization and recovery, and it has been described with the notion of *positive withdrawal* [20].

Anxiety may come in various forms in schizophrenia, i.e., from situational, usually social, and sometimes paranoid forms of anxiety, potentially intensifying into panic attacks, to a more pervasive, global anxiety. In other words, patients do typically not only feel anxious in certain mundane situations or with regard to certain delimited objects (e.g., phobias) but rather experience a kind of background or supramundane anxiety described by Laing [21] as *ontological insecurity*. Patients who feel ontologically insecure often experience themselves as painfully exposed, thrown into a world that appears unreliable or threatening, and a basic need to hide or protect oneself may ensue.

Other core experiences concern feelings of emptiness and lack of a core or inner nucleus. Patients may describe that they lack an inner standpoint to rely on, start from, and direct them in life. For example, some patients report feeling like a chameleon in social situations in the sense of being overly adaptive to accommodate others' opinions (German: *Haltlosigkeit*). This feeling has also been described as an aspect of a *diminished sense of self*. It may involve incessant questioning of the basic premises of one's identity, including one's sexuality, and it is often closely tied to *Anderssein*. The diminished sense of self may also be accompanied by an experience of *diminished presence* in the world, i.e., a feeling of decreased affectability and decreased emotional resonance and responsivity, occasionally associated with a pervasively felt distance to the world, perhaps as if there is an invisible barrier between the patient and the world.

Patients also often report various anomalous bodily experiences, including unusual bodily sensations (cenesthesias) and more pervasive feelings of being estranged from their own body, e.g., as if the body does not really fit or as if the body and mind are somehow disconnected. This experience of not feeling fully present in one's own body has been described with the concept of *disembodiment* [22, 23] and it is often accompanied by an experience of "only living in the head." Some patients express that bodily contacts with others are deeply uncomfortable, describing intense anxiety in situations where others stand too close to them, touch them or hug them. For some, such close bodily contact may be felt as a deep threat to their very existence. In these experiences, there is also an element of *loose or permeable ego-boundaries*, which articulates a range of experiences of insufficient bodily demarcation. Many patients report feeling "too open" or "without any barriers," as if others know what they are thinking or somehow have access to their inner life merely by looking at them – many patients may avoid eye contact, precisely because they fear that others may have access to their thoughts.

Finally, some patients experience a pervasive reorientation in life, with new interests (often philosophical, spiritual, or metaphysical in nature), priorities, and intentions. Here, the fundamental feeling of being different and exposed may manifest in what has been called a *solipsistic worldview* [24]. For example, some patients describe fleeting feelings of being the very center of the world or of being the only existing creature in the world or that the world exists only inasmuch as they perceive it. This may be accompanied by feelings of unique responsibilities or special insights into hidden dimensions of reality or constituting layers of consciousness, which others typically are unaware of [25]. Other patients describe that "all attention is on them" – e.g., when walking in the streets, they may feel that they "stand out" and that others look at them or talk about them, but they have no idea why others do this.

Most importantly, the core experiences that we have described here are not independent, atomic-like symptoms but interdependent, mutually implicative aspects of the underlying psychopathological Gestalt of schizophrenia. The Gestalt is a characteristic phenomenological pattern, i.e., a certain unifying structure of experiential, expressive, and behavioral phenomena. The core experiences all bear an imprint of the Gestalt in which they are embedded and from which they receive their mean-

ing, yet, at the same time, they infuse the Gestalt with its specific clinical rootedness [26, 27]. Phenomenological psychopathologists have sought to articulate the *generative disorders* (French: *troubles générateurs*) of schizophrenia in different ways. For example, Minkowski [28] identified it as *loss of vital contact with reality* (French: *la perte du contact vital avec la réalité*), Blankenburg [17] emphasized a *collapse of common sense*, and Sass and Parnas [29] proposed the *ipseity/hyperreflexivity disturbance model*.

Today, crucial aspects of the psychopathological Gestalt of schizophrenia can be systematically explored in phenomenologically based, semistructured interviews, especially in the EASE (Examination of Anomalous Self-Experience) [30] and EAWE (Examination of Anomalous World Experience) [31] interviews. Notably, patients who have participated in these interviews often remark that they were asked highly relevant questions and that the interviews addressed aspects of their life that really describe or even define them. Not infrequently, patients, who have received psychiatric treatment for years ask why nobody has ever before asked them these questions. Many patients express feelings of relief when realizing that the interviewer is familiar with the nature of their experiences or that others suffer from similar experiences. Others again appreciate getting a "vocabulary" that allows them to give a name to and thus speak about experiences that may have been almost ineffable but which often nonetheless have tormented them. Finally, many patients ask if we can help them to diminish or overcome the vulnerabilities that accompany some of the alterations of their experiential life. Over the years, many clinicians have also raised the question of how these issues can be addressed in psychotherapy. Drawing from more than a decade of experience from a psychotherapy unit at the University Psychiatric Hospital of Ljubljana (Slovenia), we will now outline what we consider tentative principles of an experience-near, phenomenological psychotherapy for schizophrenia.

Principles of Phenomenological Psychotherapy for Schizophrenia

We have divided the basic principles of such a phenomenological psychotherapy for schizophrenia into the following subgroups: (1) overall goals, (2) general attitudes, (3) main domains, and (4) therapeutic strategies.

Overall Goals

The general purpose of psychotherapy extends beyond symptom remission and can perhaps be described as that of alleviating distress, strengthening self-integration, and promoting recovery of functioning and well-being. Psychotherapy will often involve gaining an increased insight and awareness of one's vulnerabilities, acquiring capacities to handle them in different situations, and attaining more flexibility in interpersonal relationships. (1) For patients with schizophrenia, this general goal is perhaps best pursued in psychotherapy by working on diminishing the patient's feeling of self-alienation as well as of estrangement from others and the shared world. Ultimately, this may lessen or relax the feelings of being fundamentally different from others and of loneliness, anxiety, and despair, and it may allow the patient to feel more at home in the world among others. (2) Consistently, we must help patients to strengthen their sense of self and self-presence, e.g., by supporting them in their quest for personal coherence and autobiographical, narrative identity, which may, in turn, enable them to feel better integrated within themselves. (3) We must also help them to engage in and maintain meaningful interpersonal relationships, both with individual others and with groups, thereby strengthening their sense of being accepted by others and of belonging to the human community. (4) It is important to know that many of the described core experiences are trait-like rather than state-like in nature, meaning that patients usually will not be permanently relieved from them. We work psychotherapeutically with a scope of acceptance and of more neutral or even positive valuation of these experiences. They can be viewed as a form of sensitivity, openness, creativity, or awareness of different perspectives, etc. Such views may function as preventive measures against exaggerated centering or pessimistic preoccupation with these experiences.

General Attitudes

(1) To follow the described goals, we must first and foremost try to "stay with" the patients' experiences and resist interpretations, which is far from obvious in clinical practice or standard procedure in psychotherapy. In other words, if we are to thoroughly explore the experiential life worlds of our patients and avoid misunderstandings, we must stay long enough with the "how" of the experience and not rush to the "why" of the experience. For example, a patient offered the following description of her estranged relationship to her own body: "I feel I have this void inside. I try to fill it with food but that isn't working well." When asked to clarify, she said, "I think the void is

a feeling of inadequacy, loneliness, a feeling of not being sufficient, and lack of meaning. I really don't know who I am, what I'm supposed to do, and what I'm here for." To further clarify the nature of this experience, the patient was asked if the void has a spatial location. She replied, "Yes, I actually feel that it's right in the solar plexus. I feel it's gigantic, larger than my body. Like a big Pilates ball perhaps. There, I'm missing something. Some meaning is missing. I can physically feel the void. I have had it for many years. There is a space that is not filled out with anything. There's just a black void" [32]. This example illustrates the importance of staying with the "how" of experience, clarifying its nature and meaning, before inquiring into "why" she thinks she feels inadequate and lonely, lacks meaning, etc., though the latter of course also is psychotherapeutically relevant in due time. (2) In our view, this focus on staying with the "how" of the experience has not only epistemic value but also a profound emotional and relational value. Patients usually feel that they have been heard, sincerely understood, and not judged. It can be phrased in the way that the patients' experiences are welcomed with a *holding* and *containing* attitude, providing an opportunity for a *corrective emotional, relational, and embodied experience* (as it is conceptualized in psychoanalytic psychotherapy) [33]. (3) The psychotherapist's role is like that of an anchor, of a dialogue partner, and, at the same time, of a translator or bridge to the minds of others, to commonsensical knowledge, expectations, and reactions. Successfully managing this challenging role as a psychotherapist requires, in our view, solid phenomenological and psychodynamic knowledge, enabling the therapist to sincerely listen, to know how to ask questions, to know what to ask and what not to ask, and to know how and when to proceed in the psychotherapeutic process.

Main Domains

Psychotherapy covers many different domains of which we will only mention a few. (1) One important domain concerns thought process and its disturbances, e.g., thought pressure or block, ruminations, obsessions, pseudo-obsessions, failing sense of mineness of thoughts, intruding thoughts, etc. Since hyperreflectivity often is a central part of the clinical picture of schizophrenia, the therapist should be attentive not to additionally fuel an already existing hyperreflective stance, which potentially may increase patients' sense of estrangement from and distance to others and the world [34]. (2) Another important domain concerns emotions and their disturbances, e.g., feelings of an emotional barrier, anxiety, inauthenticity, defenselessness, distance, nonemotional affectivity [35], instability, ambivalence, and perplexity [36]. A very important theme in this domain is also trauma, which patients with schizophrenia often have experienced and which should be appropriately addressed in psychotherapy [37]. Here, we must also address recurrent or pervasive feelings of meaninglessness, nihilism [38], despair, and suicidality [13]. (3) Intersubjectivity constitutes another crucial domain for psychotherapy. Here, the patients' manifold experiences of problems with common sense, their difficulties with spontaneously interacting with others, and their experiences of insufficient bodily demarcation must be addressed, including their avoidance or withdrawal strategies as well as their compensatory strategies for engaging in and maintaining interpersonal relationships. (4) Also the body itself, with its palette of unusual bodily sensations, feelings of disembodiment, and dissociative phenomena, etc., which are not always easily put into words, must be explored with the patients. (5) The final domain, which we will mention here, concerns the patients' propensity to adopt a solipsistic worldview, often accompanied by existential reorientation [39], spiritual or philosophical endeavors, and sometimes mystical-like experiences. The solipsistic worldview may be part of the Bleulerian phenomenon of "double bookkeeping" by which patients, at the same time, "know the real state of affairs as well as the falsified one." [7, p. 56]. Recently, double bookkeeping has been described as a predicament of simultaneously living in 2 different worlds, i.e., the shared-social world and a private-solipsistic world [40]. Instead of trying to disprove patients' solipsistic worldview or nullify their double bookkeeping, the therapist could preferably try to balance and stabilize it, thereby helping patients to better distinguish between experiences that pertain to and are relevant for their engagement with others in the shared world and experiences that are more deeply connected to their solipsistic worldview.

Therapeutic Strategies

(1) Pursuit of the therapeutic goals as described above helps form a welcoming, humane, tolerant, and nonjudgmental psychotherapeutic environment. Many psychotherapy and community programs and settings, past and present, have documented that such an environment in itself is therapeutic – something the work in our unit of psychotherapy for psychosis in Ljubljana also testifies to. (2) In psychotherapy for schizophrenia, taking place either within or outside such therapeutic milieus, it is crucial to operate with structured and carefully planned ac-

tivities embedded in scheduled daily and weekly routines. From clinical experience and many autobiographical accounts of schizophrenia, including the exceptional one by Prof. Elyn Saks [41], we know how important an environmentally imposed or self-generated structure (also called the "exoskeleton") [42] is for treatment. (3) To facilitate a transition from a more passive, withdrawn, or observing-analyzing stance to a more active, social stance, patients often need additional support and encouragement to participate in various social activities. In our view, social activities that are organized around specific purposes and which have a temporal-spatial structure and clearly formulated rules and social roles are by many patients experienced as relatively safe, tolerable, and enjoyable, and they may be a platform to meet and interact with others and to build comradeships, friendships, and partnerships. (3) However, while encouraging patients to be socially active, we must also respect their need to organize their own personal space and accept their need to withdraw when situations become too stressful before they again find their way back to others. Crucially, such a form of positive withdrawal should not be mistaken for more malignant forms of withdrawal or taking refuge from the world of others (also called *psychic retreats)* [43].

(4) In the domain of affect and emotion regulation, we suggest turning to body-oriented psychotherapeutic strategies, e.g., relaxation techniques, mindfulness, movement therapies, and physical activities. With these strategies, we encourage patients to cultivate dereflexion, i.e., lessening of hyperreflectivity, emotional letting go, and acceptance attitudes vividly exemplified in the so-called acceptance and commitment therapy [44]. These strategies may prevent feelings of paralysis or frozenness [45], which some patients experience in social situations when they feel vulnerably exposed or defenseless in front of others. These strategies may also, in part, help patients to overcome the overwhelming consequences of physical or sexual trauma. These body-oriented psychotherapeutic strategies may also help patients to move from a passive, hyperreflective, "truth-taking stare" [46], with weakness in practical activities (French: *affaiblissment pragmatique*) to a more socially active position, catching the embodied flow, without slipping into an automatic, hyperreflective "paralysis." More generally, these body-oriented psychotherapeutic strategies may help increase a basic sense of embodiment.

(5) Finally, we want to stress that, when applying these therapeutic strategies, it is especially important to continually affirm, support, and respect patients' quests and endeavors in art, literature, science, philosophy, spirituality, etc. Many forms of art therapies can be very beneficial for encouraging, developing, and supporting these quests. In doing so, we help them find their own "islands of clarity" [47], i.e., their own sense of meaning or purpose in life, which they can express to others and pursue among them or individually. It is, after all, their life to lead.

Discussion and Conclusion

The principles of phenomenological psychotherapy described in the previous section are compatible with proposals for psychotherapy by other phenomenologically oriented authors. For example, Stanghellini and Lysaker [48] suggest that psychotherapy should focus on offering a second-person perspective within a shared partnership in order to help patients overcome difficulties in the intersubjective domain. Fuchs [49] has proposed that the scope of psychotherapy consists in diminishing the limitations of patients' lived space with re-opening their horizons of possibilities through a dyadic, experiential space, i.e., a "fusion of horizons" of the patient and the therapist. In phenomenologically informed psychotherapy, some authors have stressed the importance of patients' developing precise verbalized descriptions of their self-disorders [50] and of understanding the interrelations between self-disorders, hyperreflectivity, perplexity, emotions, life events, and goals [51]. The processes of finding appropriate descriptions of anomalous self-experiences and of reaching an understanding of these experience as they occur within the patients' life worlds unfold, in our view, together with patients' quest for meaning and coherent autobiographical narratives [52], which remain crucial for recovery [53]. The search for meaningfulness, which is a vital component of any psychotherapeutic process, is part of the psychotherapeutic relationship and may be viewed as a kind of shared meaningfulness [54].

In this article, we have emphasized certain specific goals, attitudes, domains, and strategies. While we believe that these are central and relevant in psychotherapy of schizophrenia, we are not suggesting that they are somehow exhaustive of a phenomenologically informed psychotherapy of schizophrenia. For example, we have deliberately left out the question of how to psychotherapeutically approach and treat psychosis from a phenomenological perspective. In our view, psychosis in schizophrenia may, as noted, be related to stressors or it may be more continuous but independently it will often arise on the basis of a more persistent vulnerability, which is reflected in a characteristic alteration of experiential life

and exemplified by various anomalous self-experiences. Therefore, we suggest that this basic vulnerability is a key target of psychotherapy. Notably, a phenomenological approach, as we have described here, does not rely on or provide a theory of specific intrapersonal, intersubjective, and interactional dynamics that condition the development of psychosis from the basic vulnerability. In other words, given that such a phenomenological psychotherapy for schizophrenia is not founded on a specific theory, it may be combined with other psychotherapies with different theoretical foundations; we have already indicated how it may be fruitfully combined with psychodynamic [55], mindfulness, and body-oriented psychotherapies [56]. In our view, the unique value of phenomenological psychotherapy lies in its ability to capture the heart of the patients' experiences and their inherent vulnerabilities and then use these insights to inform psychotherapeutic interventions.

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